Comprehensive Health History

Patient Name: ______________________________________ Date: _________________________________

**It is important that we know about your Dental and Medical History. These facts may have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone.*
Thank you for taking the time to fill out this questionnaire completely.

Medical History

Are you currently under the care of a physician?_________ If yes, please explain: _______________________

____

Name of physician(s): ____

Are you currently taking any prescription medications, OTC medications, or vitamins? _______ *

If yes, please list the name of ALL medications/vitamins, the reason you are taking them, and the prescribing doctor if applicable. Use the back of this sheet if necessary. If you have a list, please give it to the receptionist for a copy.

Medication:	Reason:	Prescribing Doctor:

Pharmacy: __________________________________ City of Pharmacy: ______________________________

Please check YES or NO for the following:	YES	NO
Are you currently taking prescription blood thinners?	☐	☐
Are you currently taking Aspirin daily?	☐	☐
Are you currently taking fish oil daily?	☐	☐
Women: Are you pregnant or currently breastfeeding? (Circle one)	☐	☐
Due date__________________		
Have you ever taken Bisphosphonate medication for osteoporosis? (Brand names include Fosamax, Actonel, Atelvia, Didronel, Boniva)	☐	☐
Are you allergic to latex?	☐	☐
Are you allergic to penicillin?	☐	☐
Are you aware of being allergic to any other medications or substances?	☐	☐
If yes, please list:____		
Are you currently taking sleep medication?	☐	☐

Have you EVER had any of the following? Please check all that apply:

☐ AIDS/HIV Positive
☐ Anaphylaxis
☐ Anemia
☐ Arthritis (Rheumatism)
☐ Artificial Heart Valve
☐ Artificial Hip
☐ Artificial Knee
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough (persistent)
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Food Allergies
☐ Glaucoma
☐ Headaches
☐ Head Injuries
☐ Heart Murmur
☐ Heart Problems (please describe) __________
☐ Hemophilia
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Jaw Pain
☐ Kidney Disease or Malfunction
☐ Liver disease
☐ Material Allergies (latex, wool, metal, chemicals)
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Shingles
☐ Shortness of Breath
☐ Spina Bifida
☐ Stroke
☐ Surgical Implant
☐ Swelling of Feet and Ankle
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer/Colitis
☐ Venereal Disease

Dental History

Reason for your visit today? ____

Approximately how long has it been since your last dental visit? ______________________________

Please check YES or NO for the following:	**YES**	**NO**
Have you ever responded adversely to dental anesthetic?	☐	☐
If yes, please explain: ____		
Has a medical doctor ever told you that you must take antibiotics prior to dental treatment?	☐	☐
Do you wear dentures?	☐	☐
Are you unhappy with your dentures?...	☐	☐
Would you like to know more about permanent replacements?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had any Periodontal (Gum) treatments?	☐	☐
Do your gums bleed, or feel tender or irritated?..	☐	☐
Are your teeth sensitive to hot, cold, sweets, pressure? (circle all that apply)	☐	☐
Are you unhappy with the appearance of your teeth?...	☐	☐
Do you clench or grind your teeth?..	☐	☐
Have you ever worn braces?..	☐	☐
Do you have discolored teeth that bother you?...	☐	☐
Do you regularly brush your teeth?	☐	☐
Do you regularly floss your teeth?	☐	☐

Please rank the following in order from 1-4 in which they would keep you from having dental treatment:

Fear of pain: _____ Cost of Treatment: _____ Lack of time: _____ Lack of concern: _____

Patient Signature: ____________________________ **Date:** ___________________________